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Title: **Therapeutic process issues in working with  
people who have survived repeated and prolonged  
traumatic stress**

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## **1. Definitions of traumatisation and unresolved issues**

Way back in 1955 George Kelly's said a diagnosis was: " all too frequently an attempt to cram a whole live struggling client into a nosological category" (p. 775). PTSD is a medical diagnosis and the use of this term has legal and compensation implications. The use of a nosological category has placed traumatic events and their consequences within a scientific classificatory model and that has provided considerable advantages for some traumatised people in terms of their access to treatment and compensation. The diagnostic criteria for PTSD includes a definition of a traumatic event. A traumatic event must involve actual or threatened death, or serious injury to self or others. In addition, it must include a personal response of intense fear, helplessness, or horror. Categories of intrusive, avoidance and numbing, and heightened arousal symptoms are described. Symptoms from these categories must occur in specific combinations, last for at least a month, and significantly disrupt psychosocial functioning following a traumatic event (American Psychiatric Association, 1994).

However, the diagnostic criteria for PTSD also have severe limitations and they suffer from various anomalies (Herman, 1992; 1993; March, 1993; Oksana, 1994). Classification systems inspired by the medical model have sometimes encouraged a view of traumatic stress reactions where the survivor is only seen as sick, and needing to be cured, rather than as playing a critical role in their own healing process. Such formulations sometimes seem to ignore the multiplicity of personal, trauma, and recovery factors which influence the ongoing emotional and physical health of individuals (Bannister, 1985; Winter, 1992).

Despite the long history of interest and investigation into trauma there are still few adequate theoretical models to explain the process of relationships between personal, trauma and recovery factors. Research is generally not informed by attempts to explain the processes involved in traumatisation, the substantial individual differences in response to similar traumatic events, the constellation of positive and negative sequelae following traumatisation or other relevant research (Foa & Riggs, 1993; Jones & Barlow, 1990).

There has been considerable controversy in the literature concerning what constitutes a traumatic stressor. Some arguments are associated with whether a

traumatic stressor is unique because of its magnitude or its nature. There are difficulties in determining a cut-off between extraordinary and ordinary events and deciding whether such events are continuous or discontinuous. One solution has been to incorporate the person's own evaluation of the impact of the stressor into the definition. This has been done in the DSM-IV diagnostic criteria for PTSD (American Psychiatric Association, 1994; Green, 1993). Although, a persuasive case can be made for such an approach (March, 1993), the DSM-IV criteria for PTSD may create problems in studying populations where it is not occupationally sanctioned to acknowledge feelings of intense fear, helplessness, and horror for example, in emergency personnel or war veterans. This description of a traumatic stressor may also be inappropriate for all trauma survivors with PTSD because by definition they are emotionally numb and not in touch with their feelings. The longitudinal course or natural history of PTSD is not well understood and little is known about traumatic stress reactions in different age groups especially children. There have been few systematic studies into the sequelae of prolonged and repeated traumatisation although there is substantial historical and clinical evidence to suggest that the diagnostic criteria for PTSD may be very inadequate in such cases (Herman, 1992; 1993; Oksana, 1994; Smith, 1993). There are very few methodologically sound controlled prevention and intervention studies into PTSD (Solomon et al., 1992). We do not know what happens to a person's identity, their sense of worth, their constructions of reality, or their perceptions of their personal power following traumatisation. We do not know a great deal about how a traumatised person might feel, think or behave. We do not understand the nature of secondary victimisation following traumatisation nor a lot about the characteristics and role of favourable recovery environments. We are unclear about the role and processes of confronting traumatic memories and the centrality of their influence on mental health outcome. Very little is known about survivors who make exceptional adjustments or about how traumatisation impacts on life course development. We have only minimal information on what it is like to be the partner or the child of a traumatised person. So we still have a long way to go.

In 1995, I developed and successfully empirically tested aspects of a constructivist model of traumatic stress reaction on a large population of police. As part of this process, I developed a definition of the process of traumatisation.

Traumatisation is a threat to the core processes or core roles, of an individual, organisation, community, or society. These core processes are concerned with identity or self, sense of reality, value or worth, and power (Mahoney, 1991). Core

roles involve “one’s deepest understanding of being maintained as a social being” (Kelly, 1995, p. 502). Traumatization, depending on its severity and its unique psychological proximity for an individual, is accompanied by threat, anxiety, fear, guilt, shame, and anger. These emotions have very specific definitions in this model and are explained as teaching people something about the adequacy of their attempts to make meaning from their experiences (McCoy, 1981; Neimeyer, 1993).

In other words, traumatization is a threat to our whole meaning structure. Your meaning structure “is the sum total of all the conclusions you have drawn and are always drawing from your experience, all your ideas, attitudes, expectations, opinions and beliefs. You and your meaning structure are one (Rowe, 1995 p.38)”. When we are traumatized we discover that the world is not as we interpreted it to be and we are utterly helpless and powerless in the face of some life events. We experience terror at the prospect of physical or psychological annihilation. The “symptoms” that traumatized people experience may be the only ways they can find to prevent their entire meaning structure from crumbling. Some of their “symptoms” may serve a useful purpose until they are able to find new ways of understanding their traumatic event and experience the powerfully uncomfortable feelings such as overwhelming grief and pain, shame, rage, guilt and terror associated with finding their meaning structure to have been entirely inadequate to predict or control such life events (Rowe, 1995).

## **2. Risk Assessment**

The literature on PTSD has identified the important influence of personal, trauma, and recovery factors in the development and maintenance of traumatic stress reactions.

### **Overheads 4, 5, 6**

#### **Risk Assessment for Enduring Psychological Distress Following Exposure to Traumatic Life events**

##### **Personal Factors**

pre-existing family of origin dysfunction

personal or family history of psychological distress

history of childhood abuse or prior history of other trauma exposure

neuroticism

locus of control

lower resiliency

less hardiness

younger age

### **Trauma Characteristics**

magnitude and severity of trauma exposure

multiple versus single exposure

perception of life threat or of serious injury

identification with the victim or the situation

the psychological proximity of the event

the receipt of intentional injury or harm

exposure to grotesque sights

the violent or sudden death of a loved one

learning of exposure to a noxious agent

causing death or severe harm to another

bereavement and loss

the non-accidental death of children

perceived uncontrollability and unpredictability,

### **Recovery factors**

ongoing exposure to traumatic stressors

perceived lack of consistent and quality social support

Practical Assistance

Information

Emotional Support

limited range of safe and effective strategies to deal with overwhelming feelings and heightened physiological arousal

the experience of personally significant concurrent life stressors

inability to make realistic sense out of the traumatic event and of personal reactions

### **Personal factors**

There is clear evidence that personality processes do seem to moderate the perception, evaluation, and cognitive processing of traumatic experiences (Wilson et al., 1985; Solomon et al., 1989). A constructivist model of traumatic stress reactions says that people's choices are directed towards maximising the extent to which they can predict the world, not towards maximising their pleasure as is proposed in some hedonistic explanations of behaviour (Kelly, 1955; Winter, 1992). It is proposed that personality "traits" such as "Neuroticism", "Hardiness", "Resiliency", and "Locus of Control" are not absolute and unchanging but rather fluid and fundamental personal theories or core processes confirmed by experiences. People bring these personal theories to life events resulting in specific predictions about how their owners will cope with stressors. These personal theories are complex and interrelated systems of meaning (Neimeyer, 1987a). Individual characteristics and past personal experiences influence and are influenced by these dynamic personal theories in a reciprocal and ongoing way.

### **Characteristics of Traumatic Events**

Many of the studies looking at the mental health impact of the characteristics of traumatic events assume that it is possible to disentangle the subjective impact and intensity of a particular traumatic event from specific characteristics of the traumatic event itself (March, 1993). These investigations have varied in their methodological sophistication and their findings have sometimes also been in conflict. However, it is clear that the severity and magnitude of traumatic events are extremely important and that individuals do not have to be victims to develop PTSD following a traumatic event.

The common thread linking the traumatic events in these studies is that the events were construed as a "threat" to the meaning structures of a significant number of the traumatised people in these studies.

A constructivist model of traumatic stress reactions predicts that there are some characteristics of traumatic events that are more likely to represent a threat to core

processes. For example, if emergency personnel identify with the victims, if they feel powerlessness to influence the outcome, if the event involves impossible moral choices and ethical dilemmas (ill-structured problems), and if emergency personnel perceive that their own life is in danger. These assertions are consistent with other evidence suggesting the important role of personal identification with a traumatic event on the subsequent development of trauma symptoms (Creamer et al., 1989; Higgins, 1995, Hodgkinson & Shepherd, 1994; Lipson, 1986). The profoundly negative impact of a psychologically close relationship between a perpetrator and a child has also been extensively documented in cases of child sexual assault (Bass & Davis, 1988; Herman, 1992; Oksana, 1994; Rowan & Foy, 1993; Smith, 1993). There is evidence that greater appraisal or perception of life threat is predictive of PTSD (Creamer et al., 1989; Kilpatrick et al., 1989; Riggs et al., 1992; Rowan & Foy, 1993).

These research results support a critical role for the psychological proximity of life events. The studies also indicate that the ongoing threat represented by repeated exposure to potentially traumatising events is conducive to traumatisation and unfavourable to recovery.

### **Recovery Factors**

Consistency and perceived quality of social support and willingness to self-disclose have been demonstrated to have a positive impact on the recovery of traumatised people (Alexander & Wells, 1991; Creamer et al., 1989; Dutton et al., 1994; Hodgkinson & Shepherd, 1994; Kahana et al., 1987; 1988; Keane et al., 1985). There is some evidence for the positive impact of the traumatised person understanding their subjective reactions and feeling a sense of security (Creamer et al., 1993b). Although there are few studies available, some people even appear to experience enhanced psychological functioning following recovery from traumatisation (Antonovsky, 1979; 1987; Elder & Clipp, 1988; Herman, 1992; Kahana et al., 1987; 1988; Wilson, 1988).

The trauma literature has often focussed on individual ways of coping as being a critical factor in determining who will be traumatised and by what events. Intervention efforts have frequently been targeted under the best conditions at strengthening these individual ways of coping. Under the worst conditions the traumatised individual experiences secondary victimisation and is labelled mentally ill or seen as a malingerer. This experience has been well-documented in the lives of many returning war veterans and has occurred for many other traumatised people (Herman, 1992; Wilson et al., 1988).



In this constructivist model it is suggested that societies, organisations, and families are often more willing to help facilitate change in one or several traumatised individuals or alternatively to discard, discipline, incarcerate or medicinally lobotomise them, than to look at making fundamental changes in their own ways of functioning. This is because of the threat represented by traumatised individuals and traumatic events to their own core processes and core roles.

An environment favourable to recovery from traumatisation will have the following characteristics. First, it will be validating to the formation of new personal theories (core processes). It will gently confirm a sense of personal power, unique identity, positive personal value, and a reality that can make meaning out of traumatising experiences. It will allow for the gradual development of continuity between the past, the present, and the future of the traumatised person (Viney, 1993). Second, it will be safe enough for the expression of powerful and fundamental emotions. Finally, it will be conducive to trial and error experimentation or the trying on of new personal meanings (Kelly, 1955).

Recovery environments appear to be unfavourable for many traumatised people. This has been well-documented in police, veterans, people surviving sadistic torture, internment, domestic violence, and child sexual assault (Herman, 1992; Higgins, 1995; Loo, 1993; McCann & Pearlman, 1990; Oksana, 1994; Raphael & Wilson, 1993; Wilson et al., 1988). Ideally, all people would live, work, and play in environments which were optimal to their functioning. Not only would these environments decrease the vulnerability of people to traumatisation but they would also be conducive to recovery.

### **3. The Context of Repeated and Prolonged Traumatisation**

Repeated and prolonged traumatisation occurs in many contexts such as:

#### **Overhead 7**

#### **Context of Repeated and Prolonged Traumatisation**

**Families** eg. child abuse, domestic violence, rape, sadistic organised torture and entrapment, internment and captivity

**Communities** eg. repeated physical and emotional deprivation and abuse, criminal assault, rape

**Societies** eg. war, political torture and trauma, internment and captivity, rape

**Occupations** eg. nurses, police, fire fighters, ambulance service, medical practitioners, prisoner officers

#### **4. Case Study**

The client seeking assistance is Rebecca. She has been referred by her treating GP who has recently prescribed an anti-depressant and minor tranquilliser for her symptoms of depression and anxiety. Rebecca is a 40 year old nursing sister. She has been receiving workers compensation for work related depression and anxiety and for the past two months. Rebecca's mother suffers from multiple sclerosis which was diagnosed 8 years ago. There is a family history of a relationship breakdown, substance abuse, and domestic violence on both the maternal and paternal sides of Rebecca's family of origin. There is no formal family or personal psychiatric history. Rebecca has never previously sought psychological assistance. She has never previously sought compensation and has not had any previous time off work as a result of psychological distress. Rebecca does not have a significant medical history. Rebecca has recently undergone extensive medical investigations. There is no current evidence of any physical illness except a recurrence of dermatitis on her face, arms and legs.

Rebecca is married to a police officer (James). The couple have been married for 12 years and have a 6 year old daughter (Grace) and a 3 year old son (Christopher). They moved to Canberra from QLD just after Christopher was born. The couple have no extended family in Canberra and few close friends.

Rebecca described some of her current difficulties as extreme tearfulness, intrusive auditory, kinaesthetic, visual, and olfactory flashbacks of dead and dying patients that she had treated. She has recurring nightmares of these incidents which are sometimes blurred with incidents from the domestic violence and physical abuse perpetrated by her father from birth until she left home at 17 years to take up nursing. Rebecca experiences extreme psychological and physiological reactivity to events which remind her of some of her previous patients. She feels worthless and hopeless. Rebecca has lost pleasure in previously enjoyed activities such as drawing and jazz ballet. She experiences appetite fluctuations and binge eating. She

describes herself as unable to experience the feeling of love but she expresses affection to both her children. Rebecca avoids anything to do with any hospital or illness. She experiences severe panic attacks even when she drives past a hospital. Rebecca has become increasingly social isolated and feels different from other people. Rebecca reported increasing marital difficulties and a lack of sexual desire. She has severe headaches, suicidal feelings, and a marked loss of confidence in her role as a parent. Rebecca is irritable and often cannot sleep. When she does get off to sleep she frequently wakes at 3 or 4 am. Rebecca is hypervigilant and is terrified that someone might collapse and need her help even when she goes out to do the grocery shopping.

Rebecca says she unable to identify or express her feelings except to cry, yell at James or the kids, or talk about her problems as if she is reading the news. She is having problems with her short-term memory, concentration and decision-making and has decided that she is congenitally stupid. Psychological assessment has revealed that Rebecca concurrently meets the diagnostic criteria for Chronic Posttraumatic Stress Disorder, a Major Depressive Episode, a Panic Disorder with Agoraphobia, and associated anxiety symptoms.

Rebecca blames herself for all her problems and is deeply ashamed of her perceived failures as a wife, mother, and nursing professional. James is emotionally warm and has been throughout there marriage. He is very worried about Rebecca's "loss of confidence" and says she is a wonderful wife, mother and a very competent nurse. He is at a loss to know what else he can do to help. He provides much of the childcare when he is not working and does the majority of the housework. Rebecca was doing the grocery shopping but refused to go this week. She spends most her days in her nightgown berating herself for being so useless. Rebecca is terrified that James will leave her because she cannot understand how anyone could possibly love her. Grace has just gone into Year 1 at school and has been showing severe separation problems since the beginning of the term. Christopher is sometimes waking with nightmares. He screams with terror and is not easily comforted.

Rebecca's strengths include her demonstrated capacity to work as an extremely competent nursing professional for over 23 years. Rebecca behaves in a very responsible and loving manner towards both her children. She is usually seen by others as self-assured and capable although she does not allow others to get too close.

Rebecca's immediate work supervisor is an emotionally distant woman who thinks people should "just get out the kitchen if it gets too hot". This woman is entirely devoted to her work. She is 54 years of age and has no intimate relationships. She has never been married and has no children. Rebecca has received no support or formal counselling following her exposure to potentially traumatising situations at work. She is not interested in using the available EAP services because she is worried about confidentiality and the age and relevant experience of the employed counsellors. Rebecca says she would not want to freak one of these young people out by telling them the real truth of her story. The events at work which are still relived as flashbacks or nightmares include severely beaten children and women, babies who died from SIDS, severely burned and/or mutilated accident victims, being assaulted by psychologically disturbed patients, unexpected and possibly preventable deaths in theatre, and unexpectedly getting covered in bodily fluids when she had some small nicks on her hand and may have been at risk of HIV or hepatitis.

#### **Review in terms in terms of risk assessment criteria**

### **Overhead 8**

#### **Some Sequelae Associated with Prolonged and Repeated traumatisation**

**Physiological**

**Cognitive**

**Self**

**Emotional**

**Relationships**

**Behavioural**

#### **5. Some Sequelae Associated with Prolonged and Repeated traumatisation**

**Physiological**

hypervigilance, heightened baseline levels of anxiety with out a recognisable state of calm, sleep disturbance, intense startle reactions, headaches, gastrointestinal disturbances, chronic pain, respiratory disturbances, cardiovascular difficulties, neuromuscular problems, urinary tract difficulties, skin disorders, long term effects on the neurochemical response to stress, including the magnitude of the catecholamine response, the duration and extent of the cortisol response, as well as a number of other biological systems, such as the serotonin and endogenous opioid system, alterations in immune competency, decreased hippocampal volume, extreme autonomic responses to stimuli reminiscent of traumatic events, nonhabituation to startle stimuli, amnesias and hypermnesias, traumatic memories stimulated by physiological arousal, sensorimotor rather than semantic memories

### **Cognitive**

dissociation , avoidance and minimisation of trauma-related information, disorientation in place and time, memory dysfunction, concentration problems, problems in decision-making, selective attention to threat-related cues, problems discriminating between neutral and threat-related cues, learning difficulties, cognitive distortions

### **Self**

annihilation of the meaning structure, lack of a sense of individual autonomy, loss of a sense of self, construing self as evil contaminated or tainted, lack of an internal sense of worth, perception of current reality as unsafe, continually waiting for unpredictable and uncontrollable catastrophic consequences, lack of a sense of personal power to influence the outcome of events, perception of current reality as horrible, unchangeable, and inevitably catastrophic

### **Emotional**

chronic depression, feelings of emptiness and numbness, hopelessness, powerlessness, rage, shame, guilt, chronic irritability and outbursts of rage, inability to connect feelings to bodily sensations and to thoughts, difficulty in regulating overwhelming feelings, unexpressed rage, intense self-hatred, extreme fear of making mistakes and evaluation

### **Relationships**

lack of a sense of a separate personal identity in relation to others, traumatic bonding with perpetrators, social withdrawal and constriction, patterns of revictimisation and

reenactment of the dynamics of relationships formed in traumatic environments such as approaching all relationships as if life and death issues are at stake, difficulty in establishing and maintaining healthy intimate relationships, pattern of abusive behaviour towards others, fear of intimacy yet intolerance for being alone

### **Behavioural**

constriction in initiative and future planning and active engagement in the world, chronic suicidality, repeated self-injury & sabotage, impulsive behaviours, substance abuse, overwork, eating disorders, overachievement, perfectionism, patterns of revictimisation, excessive risk-taking.

## **6. Therapeutic process issues in working with survivors of prolonged and repeated traumatisation**

### **Therapeutic Process issues**

The theoretical traditions informing psychodynamic, cognitive behavioural and information processing, biological, and socio-cultural theories of traumatic stress reactions have very different views on human nature, individual plasticity, personal power to influence the outcome of events, the self, adaptation, and the change process. In contrast to other formulations of traumatic stress reactions, a constructivist model of traumatisation emphasises lifelong development and considerable plasticity within individual limits. In this model, there is considerable opportunity to influence the outcome of events by virtue of behavioural choices but these exist within the constraints of individual contexts. The development of self is seen as essential to all viable personal change. Adaptation is seen as organising individual activity in coordination with constantly variable opportunities and confinements. The process of change results from repeated experimental efforts to gain dynamic equilibrium (Mahoney, 1991).

In this model, people who develop trauma symptoms also have a right to treatment opportunities which respect their efforts, acknowledge their courage, recognise their simultaneous strength and fragility, and empathise with the difficulty of their struggle. In a constructivist model of traumatic stress reactions, such interventions attend immediately to urgent safety and survival issues. Treatment is highly individualised and acknowledges the fluid and reciprocal relationship between people, their context, and their behaviours. Interventions are characterised by trust and confidentiality. Helping relationships are ethical, collaborative, gentle, and provide clear and

consistent support. The traumatised person is able to freely experience and express all feelings at their own pace (Neimeyer & Harter, 1988). Individuals seeking help are empowered with resources and abilities to choose their own life course. Helpers facilitate a sense of continuity between the past, present, and the future of the traumatised person (Kelly, 1955; Mahoney, 1991; Neimeyer, 1993). The therapeutic strategies used to facilitate this process can be technically eclectic providing they are both integrated and consistent with the assumptions of a constructivist model of traumatic stress reactions. For example, the exposure based treatments of the conditioning theorists can be seen as graduated trial and error experiments in formulating new meanings for traumatising events. The free association of psychodynamic formulations could be used, in collaboration with a trauma survivor, as a way of gently loosening constructs formed in traumatic environments (Bannister & Fransella, 1986; Neimeyer, 1988; Winter, 1992). Such an approach allows for both treatment versatility and theoretical coherence (Harter, 1988; Neimeyer, 1988; 1993).

## **Overhead 10**

### **Therapeutic process issues**

#### **Physical and Psychological safety issues**

##### **Medical Assessment**

##### **Psychological Assessment**

#### **The unique nature, opportunities and dangers of therapeutic relationships**

**Establish and closely monitor systems for the worker to proactively take full responsibility for their own self-care**

#### **The therapeutic relationship**

**transference issues**

**countertransference issues**

**Establish clear lines of communication and responsibility with the multiple professionals involved**

**Establish a therapeutic relationship and collaboratively negotiated therapeutic goals with regular joint reviews of progress within negotiated time frames**

**Collaboratively develop personalised and culturally relevant strategies to constructively express and reclaim powerful feelings and bodily sensations,**

**Strategies to identify and gently but firmly challenge currently unhelpful ways of thinking that may have been viable and/or developmentally appropriate in traumatic environments**

**Strategies to safely experiment with alternative ways of being in and acting upon the world**

**Quality and quantity of social support**

**Timing of trauma work**

**Balance between focus on current life events and reassociating traumatic material**

**The process of trauma reassociation**

**The role of techniques and their purpose**

**Termination**

### **Physical and Psychological safety issues**

A major theme at this time is to repeatedly emphasise strengths of traumatised people rather than their deficits (See Rebecca's case).

- structural and psychological interventions concerning physical and psychological safety. eg. change of accommodation or removal of perpetrator in cases of domestic or organised sadistic violence,
- identification of triggers to intense psychological or physiological reactions
- collaborative development of immediate and personalised strategies to deal constructively with overwhelming feelings including rage, excruciating emotional pain, and terror eg. frame and shrink intrusive traumatic events with a view to re-visiting these events at a less volatile and safer time, discuss creative alternatives to self-injury, develop suicidal and homicidal contracts, identify and discuss the advantages and disadvantages of hospitalisations;



- explore and monitor the range and type of viable work duties, assist the traumatised person to negotiate compensation and return to work plans where relevant
- encourage clients to leave most major life decisions (except those concerned with immediate safety) until they are past the immediate presenting crisis,
- assist the traumatised person to provide time and space for their own healing process whilst minimising current day losses and maintaining current strengths,
- meet with safe and supportive family members with the informed permission of the client and explain therapeutic process issues. Assess and arrange assistance for other family members to help ensure they can meet their own psychological and social needs. Determine the ability and commitment of safe family or close friends to help provide a favourable recovery environment for the traumatised person
- review financial considerations in terms of the clients survival and negotiate a viable consultation fee.

### **Medical Assessment**

- to screen and identify any untreated physical condition which may reciprocally interact with the intensity of psychological distress experienced by the traumatised person.

### **Psychological Assessment**

- thorough identification of presenting difficulties and strengths across the major areas of functioning,
- generational psychosocial history,
- generational and personal history of trauma,
- substance use and medical history,
- occupational history,
- relationship history,
- therapeutic history,
- current social networks and their perceived quality,
- concurrent life stressors,
- rationale and feelings associated with the traumatised person seeking help,

- the traumatised person's account of precipitating events leading up to this current presentation,
- current personal attempts to heal and restraints to progress.
- This process may include both structured interviews and formal psychometric testing depending on the needs and priorities of the particular traumatised person. Such a process is likely to uncover various comorbid problems which are commonly associated with traumatisation eg depression, substance abuse, social phobias, panic disorders, obsessive-compulsive problems, PTSD, borderline personality characteristics, and DID.
- The psychological assessment process can enable the traumatised person to begin to take some very early fledgling steps towards making links between past, present, and future behavioural options and to begin to understand the survival value of their trauma symptoms within traumatising environments eg. the good sense but terrible isolation of shutting down emotionally when there was no-one to provide safe nurturance, the wisdom but concurrent pain of replaying the traumatic event until the traumatised person can predict when or if such an event might happen again, the ingenuity but enormous physical and psychological strain of remaining very wound up when the traumatised person did not know when or if they might have to fight, run away, or simply be trapped and endure another traumatising event., the absolute brilliance but devastating confusion of disassociating the feelings or even the entire content of life events that are completely overwhelming.
- The worker can provide lots of well timed and highly personalised additional information during this early stage so that the traumatised person can begin to consider alternative ways of making meaning out of their traumatic experiences.
- Summarise key risk assessment issues by reviewing personal, trauma, and recovery factors. This can act as a guide to collaborative treatment planning.

### **The unique nature, opportunities and dangers of therapeutic relationships**

- be very clear with yourself that you are not using the inherent power differential of therapeutic relationships inappropriately to meet unresolved personal needs to feel less vulnerable by abuse power, to rescue, to focus on other people's issues to avoid your own, or to have a group of captive and very grateful admirers.
- Discuss what can and cannot be expected in relation to ethical practice, availability, reliability, and other boundaries eg. the differences between a therapeutic

relationship and a friendship or other intimate relationship eg. the integrity of the therapeutic time and space, worker responsibility for self-care, and the role and rationale for very selective and client-focussed self-disclosure by the worker .

- Provide accurate information about the processes and sequelae of repeated traumatisation and help universalise the common difficulties of traumatised people by emphasising all the work that has been done in this area. Normalise the range of symptoms and their severity.
- Repeatedly assure the person that they are not mad, bad, wrong, irrational, or infantile but still using strategies which were viable in traumatising environments but are less likely to be useful in healthy environments and within healthy relationships. Repeatedly emphasise that these symptoms have developed with protective intent and need to be fundamentally respected. The traumatised person can then begin to gently but firmly challenge their current utility and experiment with alternatives.
- Pre-empt straight talk about triggering behaviour, appearance, or relationship dynamics, and normalise the need to discuss “hiccups” or more serious concerns within the relationship.

**Establish and closely monitor systems for the worker to proactively take full responsibility for their own self-care**

- This issue is extremely important in light of the significant risk of vicarious traumatisation when working with people who have been repeatedly traumatised especially by other people. Particular risks for vicarious traumatisation include exposure to multiple trauma stories, empathic sensitivity to suffering, and unresolved personal emotional issues that relate symbolically or affectively to the traumatic experience.
- Worker self-care is critical in maintaining congruence between what the worker says and what the worker does and in minimising the risk of retraumatisation and re-enactment of traumatic relationship dynamics within the therapeutic relationship. Strategies might include: completing your own therapeutic work prior to commencing this work, regular professional consultations with a trusted colleague/s to explore the triggering impact of trauma work on personal issues, ensure regular constructive expression of the full range of feelings elicited during the work to prevent emotional numbing and empathic failure, identify and constructively address challenges to the workers own meaning structure made very likely by the very horror and devastation

of some trauma stories and possibly manifested in feelings of helplessness and personal vulnerability.

- Develop and maintain a balance between trauma and other clinical work and other professional activities eg teaching, research, supervision; proactively develop and maintain your own physical, psychological, and social health in the uniquely diverse ways that we can all create for ourselves

## **The therapeutic relationship**

**transference issues** dependency and seeking exclusive re-parenting, wanting to be rescued rather than helped, financial drain, anger, safety, control, power, testing interpersonal limits and boundaries, rebonding, mistrust, hatred, sexual attraction, setting the worker up to fail like every other interpersonal relationship, becoming the target of revenge for all people who abused their power, love, idealisation.

### **countertransference issues**

- avoidance of the trauma story eg. blank screen, over focus on pre-morbidity or concurrent life stressors, over medication, distortion, and disillusionment, misperceptions of therapeutic dynamics
- overinvolvement eg. blurring of boundaries, overcommitment, dependency on clients to meet needs,
- empathic distress and increased arousal eg. anxiety over professional efficacy, need to establish control and reduce sense of uncertainty and vulnerability, fear of affective intensity in the client, fear of personal vulnerability and potential for victimisation, conception of self as rescuer, gifted healer, saviour; anger and rage at the source of victimisation, dread, horror, disgust and image of the client as weak or pitiful, sadness, grief, shame, guilt, over being exempted and not suffering, feeling overwhelmed, voyeurism
- unwillingness to allow time for full cognitive, behavioural, and emotional integration of a traumatic experience so as to “do the therapy by bursting boils”

### **Establish clear lines of communication and responsibility with the multiple professionals involved**

- in any particular case with the informed permission of the client eg GP, psychologists, psychiatrists, social workers, counsellors, rehabilitation provider, agency case manager, insurer, unions, managerial and supervisory staff

### **Establish a therapeutic relationship and collaboratively negotiated therapeutic goals with regular joint reviews of progress within negotiated time frames.**

- Clearly but gently and firmly articulate who seeks and who owns the responsibility for therapeutic change eg. negotiation and compliance with tasks to complete outside of therapeutic consultations, arriving on time for appointments, policies re missed appointments and notification times.

- Pre-empt the fluid, reciprocal, and developmental nature of trust and safety issues based on experience especially for people who have survived prolonged and repeated traumatisations. Normalise and set ongoing clear limits around testing behaviour eg. arriving sober to appointments, being unwilling to accept physical or emotional threat or violence. Empower the client with the information that there is a need both within and outside therapy to integrate the **B**ehaviour, **A**ffect, **S**ensation, and **K**nowledge of a traumatic event.

**Collaboratively develop personalised and culturally -relevant strategies to constructively express and reclaim powerful feelings and bodily sensations**

- to proactively lower heightened physiological arousal, to self-soothe and to begin safely challenge trauma-related meanings and anticipations associated with repeated assaults to identity, power, current reality, worth, and core social roles. Such strategies might include selective self-disclosure, physical release of anger, creative writing, singing, playing a musical instrument, drawing, painting, dancing, meditation, exercise, self-defence, and grieving and healing ceremonies.

**Strategies to identify and gently but firmly challenge currently unhelpful ways of thinking that may have been viable and/or developmentally appropriate in traumatic environments**

eg. black and white thinking, catastrophic thinking, overgeneralisation, personalising, turning a positive into a negative, anticipating emotional deprivation, abandonment, and betrayal of trust. Perception of self as defective and shameful, socially undesirable, as a congenital failure, as dependent and as especially vulnerable. Confusion about who owns which problems and repeated subjugation of personal needs. Self-sacrifice and unrelenting standards. Identifying these core beliefs which were developed, validated, and had survival value in traumatic environments and gradually developing a new personal narrative which allows development of new meanings for self, worth, reality, power and fundamental social roles.

**Strategies to safely experiment with alternative ways of being in acting upon the world**

eg learning to accept compliments rather than selectively attending to evidence that confirms self-denigrating beliefs, developing and acting upon clear criteria for healthy relationships, collaborative negotiation of behavioural tasks that result in feelings of pleasure and competence, self-caring and exploration of strategies that may begin to

address unmet and yet critical developmental needs eg trust, initiative, autonomy, intimacy, integrity, and reclaiming creativity, spontaneity, and power

### **Quality and Quantity of Social support**

- determining who is emotionally available and willing to provide support and work on building these networks whilst simultaneously identifying and challenging abusive relationships, self-denigration, shame, and boundary confusion which might make this process difficult.

### **Timing of trauma work**

- This issue is about the if, when, and the order of work of the reassociation of traumatising events in the context of the likely temporary exacerbation of trauma symptoms. Trauma reassociation needs to take place with real safety. Current and future environmental contexts need to help inform this decision including the degree of trust within the therapeutic relationship and the traumatised person's current personal stability and concurrent life stressors. Survivors of repeated and prolonged traumatisation usually seem to reassociate the least traumatic material first. Traumatized people can sometimes make excellent decisions about these timing issues especially when they have genuinely begun to trust their own judgment, when they are in touch with their feelings and bodily sensations, and when they can challenge unhelpful ways of thinking. The worker can facilitate the likelihood of a sound decision by expressing any serious reservations and its rationale when appropriate or by confirming the wisdom of the traumatised person to know what is best for them.

- Successful and healing trauma reassociation is not about lancing boils or learning to remain unfeeling in the face of extreme human devastation and horror. The aim is not re-traumatisation or the production of robot like responses to very real and very tragic events. Trauma work is about developing a current way of understanding traumatic events which fully acknowledges and embodies the profound emotional impact of traumatising events but no longer allows the expectations, feeling, and behaviours developed and validated in traumatic events to dominate either the present or the future of the traumatised person

### **Balance between focus on current life events and reassociating traumatic material-**

Allow time between trauma re-association to draw connections between traumatic ways of thinking, feeling, and behaving and current and future behavioural options.

Look at history and patterns of re-enactment of this trauma eg self-sabotage, inappropriate intensity of feelings to current life events, dissociation, emotional numbing and avoidance strategies. Develop clear plans and strategies for responsibly managing the emotional intensity throughout a consultation

### **The Process of Trauma Reassociation**

It is important that the traumatised person have a personalised safe place to begin from to which to return during trauma reassociation work. It is imperative that the traumatised person be totally in charge of when they enter and when they return from a traumatic memory so as to not re-confirm experience of helplessness and powerlessness. The worker should provide no trauma content whatsoever but simply ask open ended questions such as: What is happening now? What do you see? What do you hear? What do feel? What are you touching? Who is there? What do you smell? It is critical that person reclaim hurt and/or child parts during the process with whatever resources required. Otherwise the only difference between this experience and original trauma will be your presence outside the trauma which may or may not make a difference. Resist that temptation to overcome your own horror and helplessness by offering to be a part of the reclaiming process, unless specifically asked. Strongly encourage the adult survivor do the rescuing not you. The person must be re-oriented to time and place before leaving the consultation.

### **The role of techniques and their purpose**

It is very important to have a clear theoretical rationale for any strategies used and clear evidence that they are unlikely to cause any harm. It is critical that the rights of the traumatised person to informed consent be respected. I have concerns about the abuse of some of the new “power” alphabet therapies eg. EDMR, thought field therapy (TFT), NLP, Traumatic Incident Reduction (TIR). There also are recent worrying trends like people on the internet calling themselves Master Traumatologists. Fortunately, most of the major proponents of these therapies do not recommend their use with survivors of repeated and prolonged traumatisation. Hypnosis is strongly discouraged in treating traumatised people because of issues associated with control and power and the distinct possibility that dissociated traumatic memories may emerge.

**Termination** If these processes are followed, termination of therapy is unlikely to present major problems because you will simply become redundant. A good sign that you are getting close is when the traumatised person starts to tell you about helpful ways of thinking, expressing feelings, or behaving as if that was the first time you had



heard it. Termination may temporarily trigger unresolved feeling of abandonment and loss but the traumatised person will be well-equipped to identify and deal constructively with these feelings when termination is indicated.

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